Business Statistics in October of the previous two years. Facilities that are relocated within the investment per bed limit may be approved by the statewide advisory committee.

(2) Rate adjustments for facilities that relocate within the investment per bed limit are reviewed by the statewide advisory committee.

C. Costs for relocation exceeding the investment per bed limit are absorbed by the facility.

Section 11.060 **Payment for persons with special needs for crisis intervention services.** Community-based crisis services authorized by the Department, to a resident of a facility paid under this section, is paid by medical assistance in accordance with items A to F.

A. "Crisis services" means the specialized services listed in subitems (1) to (4) purchased under contract by the facility for a resident to prevent the resident from requiring placement in a more restrictive institutional setting such as an inpatient hospital or regional treatment center and to maintain the recipient in the present community setting. The crisis services provider:

(1) Assesses the recipient's behavior and environment to identify factors contributing to the crisis.

(2) Develops a resident-specific intervention plan in coordination with the service planning team and provides recommendations for revisions to the individual service plan if necessary to prevent or minimize the likelihood of future crisis situations. The intervention plan must include a transition plan to aid the resident in returning to the community-based ICF/MR if the resident is receiving residential crisis services.

(3) Consults with and provides training and ongoing technical assistance to the resident's service providers to aid in the implementation of the intervention plan and revisions to the individual service plan.

(4) Provides residential crisis services in an alternative, state-licensed setting approved by the Department when a facility is not able, as determined by the Department, to provide the intervention and protection of the resident and others living with the resident that is necessary to prevent the resident from requiring placement in a more restrictive institutional setting.

B. Payment for crisis services in item A is made only for services provided when the facility has executed a cooperative agreement with the crisis services provider to implement the intervention plan and revisions to the individual service plan as necessary to prevent or minimize the likelihood of future crisis situations, to maintain the resident in the present community setting, and to prevent the resident from requiring a more restrictive institutional setting.

C. Payment for residential crisis services is limited to 21 days, unless an additional period is authorized by the Department or part of an approved regional plan.

D. Payment to the facility is made for up to 18 therapeutic leave days during which the resident is receiving residential crisis services, if the facility is otherwise eligible to receive payment for a therapeutic leave day under Minnesota rules governing therapeutic leave.

E. Payment rates for crisis services are established consistent with county negotiated crisis intervention services.

F. Payment under this section will be terminated if the Department determines that the facility is not meeting the terms of the cooperative agreement under item B or that the resident will not return to the facility.

## ATTACHMENT 1

## METHODS AND STANDARDS FOR DETERMINING PAYMENT RATES PRIOR TO OCTOBER 1, 2000 FOR SERVICES PROVIDED BY INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED (ICFs/MR) WHICH ARE NOT STATE-OWNED

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# METHODS AND STANDARDS FOR DETERMINING PAYMENT RATES PRIOR TO OCTOBER 1, 2000 FOR SERVICES PROVIDED BY INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED (ICFs/MR) WHICH ARE NOT STATE-OWNED

## SECTION 1.000 INTRODUCTION.

Section 1.010 **General purpose.** The purpose of Minnesota's methods and standards for determining medical assistance payment rates for ICFs/MR that are not state-owned is to provide for rates in conformity with applicable state and federal laws, regulations and quality and safety standards. Minnesota has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act. In determining the rates, the Department of Human Services takes into account the provider's historical costs, the size of the facility, and other factors.

Facilities participating in the Minnesota Medical Assistance Program are paid by a prospective rate-setting methodology. This methodology, established in Minnesota statutes and rules, is described in this attachment. This attachment describes policies concerning cost classification and allocation procedures, both allowable and nonallowable costs, reporting requirements, cost allocation and classification principles, appeal procedures, and rate-setting procedures for newly established facilities or approved facility Class A to Class B bed conversions.

Section 1.020 **Overview.** A very brief description of the overall rate setting mechanism will be helpful. Cost reports are submitted annually by ICFs/MR for the common reporting year of January 1 to December 31. The common rate year of October 1 to September 30, lags the report year by nine months. The submitted cost reports are desk audited to determine allowable operating costs and subject to various cost category limitations. Similarly, property costs including depreciation, interest, and lease expenses are reviewed, and subjected to cost limitations such as investment limits, debt limits, interest rate limits, and down payment requirements. The property rate may also be adjusted for certain life safety code changes. Payment rates are set for the rate year of October 1 to September 30 following the cost reporting year by adjusting per diem costs for inflation. These payment rates are subject to appeal, and may be adjusted retrospectively for field audit and appeal resolutions.

The total payment rate for ICFs/MR is the sum of the total operating cost payment rate, the special operating cost payment rate, and the property related payment rate. The rate may also include a program operating cost adjusted for recognized deficiencies or need determinations resulting from governmental programmatic reviews. These three rates can be summarized as follows:

A. Operating costs.

(1) Program operating costs. These include such items as program staff salaries, nursing salaries, applicable fringe benefits and payroll taxes, supplies, staff training, purchased services, resident transportation, vacations, and membership fees, as well as some repairs related to resident behaviors.

(2) Maintenance costs. These include dietary staff salaries, supplies, and raw food, housekeeping costs, laundry and linen costs, plant operating and maintenance costs such as salaries, utilities, and repairs, and applicable fringe benefits and payroll taxes.

(3) Administrative costs. These include administration, housekeeping and clerical salaries, office supplies, professional development, working capital interest expense, general facility costs, management/consulting services, legal and accounting fees, and applicable fringe benefits and payroll taxes.

(4) Wage equity salary cost adjustment of 3% for the period July 1, 1998 to September 30, 2000. The adjustment is subject to retroactive reviews with recovery of overpayments.

B. Special operating costs.

(1) Real estate taxes and special assessments

(2) Real estate insurance

(3) License fees.

(4) Professional liability insurance.

(5) Amortization of reopening costs.

(6) Training and habilitation costs.

(7) Property modifications or equipment cost allowed as life safety code improvements.

Effective October 1, 1995, real estate insurance and professional liability insurance costs are not considered in computing the payment rate for special operating costs. For purposes of

reimbursement, these are included with the general operating costs.

C. Property related costs.

(1) Allowance for depreciation of capital assets (does not include land).

(2) Capital debt interest expenses.

(3) Rental and lease payments.

(4) Other payments as permitted under Sections 9.050, 9.060, 10.000, 14.070 and 14.100 of this attachment.

Section 1.030 **Definitions.** For the purposes of Sections 2.000 to 17.060, the following terms have the meanings given them in this section.

**Addition.** "Addition" means an extension, enlargement, or expansion of the physical plant of an ICF/MR for the purpose of increasing the number of licensed beds or improving resident care.

**Applicable credit.** "Applicable credit" means a receipt of funds or an expense reduction as a result of public grants, purchase discounts, allowances, rebates, refunds, adjustments for overcharges, insurance claims settlements, recovered bad debts, or any other adjustment or income which reduce the costs claimed by the facility.

**Capacity days.** "Capacity days" means the total number of licensed beds in the facility multiplied by the number of days in the reporting year.

**Capital assets.** "Capital assets" means a facility's land, physical plant, land improvements, depreciable equipment, leasehold improvements, capitalized improvements and repairs, and all additions to or replacement of those assets.

**Capital debt.** "Capital debt" means a debt incurred by the facility for the purpose of purchasing a capital asset, to the extent that the proceeds of the debt were actually applied to purchase the capital asset including points, financing charges, and bond premiums or discounts. Capital debt includes debt incurred for the purpose of refinancing a capital debt.

**Capital debt interest expense.** "Capital debt interest expense" means interest payable under the terms of a capital debt, amortization of a bond premium or discounts, and amortization
of financing charges.

**Class A beds.** "Class A beds" means beds licensed for ambulatory and mobile persons who are capable of taking appropriate action for self-preservation under emergency conditions as determined by state and federal licensing law.

**Class B beds.** "Class B beds" means beds for ambulatory, nonambulatory, mobile, or nonmobile persons who are not mentally or physically capable of taking appropriate action for self-preservation under emergency conditions as determined by state and federal licensing law.

**Commissioner.** "Commissioner" means the commissioner of the Minnesota Department of Human Services.

**Cost categories.** "Cost categories" means any one of the groupings of costs as defined in Sections 6.010 through 6.060.

**Cost report.** "Cost report" means the document and supporting materials specified by the commissioner and submitted by the provider for the facility. The cost report includes the statistical, financial, and other relevant information required in Sections 2.010 through 2.070.

**Department.** "Department" means the Minnesota Department of Human Services.

**Depreciable equipment.** "Depreciable equipment" means the standard moveable resident care equipment and support service equipment generally used in an ICF/MR. Depreciable equipment includes the equipment specified in the major moveable equipment table of the depreciation guidelines.

**Depreciation guidelines.** "Depreciation guidelines" means The Estimated Useful Lives of Depreciable Hospital Assets, issued by the American Hospital Association, 840 North Lake Shore Drive, Chicago, Illinois (Chicago: 1983). The depreciation guidelines are incorporated by reference and are available for reference at the Minnesota State Law Library, Minnesota Judicial Center, 25 Constitution Avenue, Saint Paul, Minnesota, 55155. Only the 1983 publication will be used and will not change.

**Desk audit.** "Desk audit" means the determination of the facility's payment rate based on the commissioner's review and analysis of required reports, supporting documentation, and work sheets submitted by the provider.

**Direct cost.** "Direct cost" means a cost that can be identified within a specific cost category without the use of allocation methods.

**Equity.** "Equity" means the historical capital cost of the facility's capital assets subject to the limitations in Section 9.010, item C, and Section 9.030, item H, decreased by the outstanding principal amount of the capital debts, and the historical capital cost of any capital assets retired from service, sold, or other wise disposed. Increases in the principal amount of existing capital debts due to refinancing, or new capital debts due to a change of ownership or reorganization of provider entity for which the increase in interest expense is disallowed according to Section 9.030, item G are not included in the outstanding principal amount of the capital debts for the purpose of calculating equity.

**Facility.** "Facility" or "ICF/MR" means a program licensed to serve persons with metal retardation or related conditions under state laws, and a physical plant licensed as a supervised living facility under state laws, which together are certified by the Minnesota Department of Health as an intermediate care facility for the mentally retarded.

**Field audit.** "Field audit" means the on-site examination, verification, and review of the cost report, financial records, statistical records, and related supporting documentation of the provider or provider group.

**Fringe benefits.** "Fringe benefits" means workers' compensation insurance (including self-insurance plans described in Section 4.170), group health insurance, disability insurance, dental insurance, group life insurance, and retirement benefits or plans.

**Funded depreciation.** "Funded depreciation" means the sum deposited in a separate account as determined in accordance with Section 9.010, item E, and that must be applied only to reduce or liquidate capital debts or replace capital assets.

**Historical capital cost.** "Historical capital cost" means:

A. for a capital asset first placed in use in the medical assistance program on or after January 1, 1984, the cost incurred to construct or purchase the capital asset by the person or entity owning the capital asset on the date it was first placed in use in the medical assistance program; and

B. for a capital asset first placed in use in the medical assistance program prior to January 1, 1984, the cost originally incurred to construct or purchase the capital asset by the person or entity owning the capital asset on December 31, 1983.

**Historical operating costs.** "Historical operating costs" means the allowable operating costs incurred by the facility during the reporting year immediately preceding the rate year for which the payment rate becomes effective after the commissioner has reviewed those costs and determined them to be allowable costs under the medical assistance program and after the application of Sections 1.010 to 17.060.

**Indirect cost.** "Indirect cost" means a cost incurred for a common or joint purpose of benefitting more than one cost category or not readily assignable to the cost categories benefitted.

**Land.** "Land" means the land owned or leased by the provider or provider group and which is necessary for resident care.

**Land improvement.** "Land improvement" means an improvement to the land surrounding the facility as specified in the land improvements table of the depreciation guidelines, if the land improvement is the responsibility of the provider.

**Leasehold improvement.** "Leasehold improvement" means an improvement to property leased by the provider for the use of the facility that reverts to the owner of the property upon termination of the lease.

**Medical assistance program.** "Medical assistance program" means the program that reimburses the cost of health care provided to eligible residents pursuant to state and federal law.

**Necessary service.** "Necessary service" means a function pertinent to the facility's operation that if not performed by the assigned individual would have required the provider to employ or assign another individual to perform it.

**Payroll taxes.** "Payroll taxes" means the employer's share of social security withholding taxes, and state and federal unemployment compensation taxes or costs.

**Physical plant.** "Physical plant" means the building or buildings in which a program licensed to provide services to persons with mental retardation or related conditions under state law is located, and all equipment affixed to the building and not easily subject to transfer as

specified in the building and fixed equipment tables of the depreciation guidelines, and auxiliary buildings in the nature of sheds, garages, and storage buildings located on the same site if related to resident care, and the allocated portion of office space if the office is located in that facility. Physical plant does not include buildings or portions of buildings used by central, affiliate, or corporate offices if those offices are not located in that facility.

**Private paying resident.** "Private paying resident" means a facility resident whose care is not paid for by the medical assistance program, cost of care program, or the Community Social Services Block Grant for the date of service.

**Program.** "Program" means those functions and activities of the facility that contribute to the care, supervision, developmental growth, and skill acquisition of the residents under state and federal laws.

**Program director.** "Program director" means the person who supervises individual program planning and program activities related to carrying out the individual program plans.

**Provider.** "Provider" means the corporation, governmental unit, partnership, person, or persons licensed to operate the facility, which controls the facility's operation, incurs the costs reported, and claims reimbursement under Sections 1.010 to 17.060 for the care provided in the facility.

**Provider group.** "Provider group" means a parent corporation, any subsidiary corporations, partnerships, management organizations, and groups of facilities operated under common ownership or control that incurred the costs shown on the cost report which are claimed for reimbursement under Sections 1.010 to 17.060.

**Rate year.** "Rate year" means the period for which the total payment rate is effective, from October 1 to September 30.

**Related organization.** "Related organization" means a person that furnishes goods or services to a facility and that is a close relative of a provider or a provider group, an affiliate of a provider or provider group, or an affiliate of a close relative of an affiliate of a provider or provider group. For the purposes of this definition, the following terms have the meanings given them.

A. "Affiliate" means a person that directly, or indirectly though one or more intermediaries, controls, or is controlled by, or is under common control with another person.

B. "Person" means an individual, a corporation, a partnership, an association, a trust, an unincorporated organization, or a government or political subdivision.

C. "Close relative of an affiliate of a provider or provider group" means an individual whose relationship by blood, marriage, or adoption to an individual who is an affiliate of a provider or provider group is no more remote than first cousin.

D. "Control" including the terms "controlling", "controlled by", and "under common control with" means the possession, direct or indirect, of the power to direct or cause the direction of the management, operations, or policies of a person, whether through the ownership of voting securities, by contract or otherwise.

**Repair.** "Repair" means the cost of labor and materials needed to restore an existing capital asset to sound condition after damage or malfunction or to maintain an existing capital asset in a usable condition.

**Replacement.** "Replacement" means a renovation or substitution of an existing capital asset to improve its function or extend its useful life.

**Reporting year.** "Reporting year" means the period from January 1 to December 31 immediately preceding the rate year, for which the provider submits its cost report, and that is the basis for the determination of the total payment rate for the following rate year.

**Resident day.** "Resident day" means a day on which services provided to residents are rendered and billable, or a day for which a bed is held and billed.

**Respite care.** "Respite care" means short-term supervision, assistance, and care provided to persons with mental retardation or related conditions due to the temporary absence or need for relief of the caregiver who normally provides these services and is not an institutional provider.

**Top management personnel.** "Top management personnel" means owners, corporate officers, general, regional, and district managers, board members, administrators, the facility administrator, and other persons performing executive functions normally performed by such personnel, whether employed full time, part time, or an a consultant. The facility administrator is the person in charge of the overall day-to-day activities of the facility.

**Total payment rate.** "Total payment rate" means the amount established by the commissioner to reimburse the provider for service provided to each resident. The total payment rate is calculated by adding the total operating cost payment rate, the special operating cost payment rate, and the property-related cost payment rate.

**Useful life.** "Useful life" means the length of time a capital asset is expected to provide economic service before needing replacement.

**Vested.** "Vested" means the existence of a legally fixed unconditional right to a present or future benefit.

**Working capital loan.** "Working capital loan" means a debt incurred to finance a facility's operating costs. A working capital loan does not include a debt incurred to acquire or refinance a capital asset.

**Working capital interest expense.** "Working capital interest expense" means the interest incurred on working capital loans during the reporting year.

## SECTION 2.000 GENERAL REPORTING REQUIREMENTS.

Section 2.010 **Required cost reports.** No later than April 30 of each year, the provider shall submit an annual cost report on forms supplied by the Department in order to receive medical assistance payments. The reports must cover the reporting year ending December 31, except that for reporting years ending on or after December 31, 1987, (effective January 19, 1988) a provider operating a facility that is attached to a nursing home that is reimbursed under the rate setting requirements for nursing homes may elect to report the facility's costs and statistical information for the period covered by the nursing home's reporting year. If a certified audit has been prepared, it must be submitted with the cost report. In addition, a provider or provider group which has 48 or more licensed beds shall submit an annual certified audit of its financial records obtained from an independent certified public accountant or licensed public accountant. The examination must be conducted in accordance with generally accepted auditing standards as adopted by the American Institute of Certified Public Accountants and generally accepted accounting principles. A government owned facility may comply with these auditing requirements by submitting the audit report prepared by the state auditor.

Section 2.020 **Required information.** A complete annual cost report must contain the following items:

A. General facility information and statistical data as requested on the cost report form.

B. Reports of historical operating costs and property-related costs with supporting calculations and worksheets as requested on the cost report form.

C. The provider's balance sheet and income statement for each facility prepared in accordance with generally accepted accounting principles unless audited financial statements are required to be submitted. In this case the facility must submit a copy of its audited financial statements for the reporting year. The audited financial statements must include a balance sheet, income statement, statement of retained earnings, statement of changes in financial position, notes to the financial statements, and supplemental information, as required of an audit conducted in accordance with generally accepted auditing standards, and the certified or licensed public accountant's opinion. If the financial statements are not sufficiently detailed or the facility's fiscal year is different from the reporting year, the facility shall provide supplemental information that reconciles costs on the financial statements with the cost report.

D. Effective for the reporting year ending December 31, 1993, a facility is no longer required to have a certified audit of its financial statements. The cost of a certified audit shall not be an allowable cost in that reporting year, nor in subsequent reporting years, unless the facility submits its certified audited financial statements in the manner otherwise specified in this Section. A facility which does not submit a certified audit must submit its working trial balance as part of the annual cost report.

E. A list of the provider's capital debts and working capital loans outstanding for each facility during the reporting year, the name of the lender, the term of the debt, the interest rate of the debt, interest and principal payments for the current year, and the original amount of each loan.

F. A schedule of the provider's funded depreciation account for each facility.

G. A statement of ownership for the facility, including the name, address, and proportion of ownership of each owner, or a statement that no changes have been made since the last cost report.

If a privately-held or closely-held corporation or partnership has an ownership interest in the facility, the facility must report the name, address, and proportion of ownership of all owners of the corporation or partnership who have an ownership interest of five percent or more, except that any owner whose compensation or portion of compensation is claimed for